

Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Savings and Reimbursement

Thursday, March 6, 2008

2:00 - 3:30 p.m. Eastern

Edwina Rogers

The Patient Centered Primary Care
Collaborative

and

The ERISA Industry Committee

Paul Grundy

The Patient Centered Primary Care
Collaborative *and*

IBM Global Wellbeing Services and Health
Benefits

Melinda Abrams

The Commonwealth Fund

Neva Kaye

National Academy for State Health Policy

Carol Steckel

Alabama Medicaid Agency

Christopher Koller

Rhode Island Office of the Health
Insurance Commissioner

Robyn Hoffmann

ACS, Inc. for the Rhode Island Department
of Human Services

Supported by The Commonwealth Fund

The Patient Centered Primary Care Collaborative

Edwina Rogers,
Vice President, Health Policy, The ERISA Industry Committee
Executive Director, The Patient Centered Primary Care Collaborative



The Problem

- Employers want to buy high quality healthcare for their employees, but cannot buy the model of health care they want.
- The reimbursement system is inadequate, health information technology is insufficient, and accountability and incentives are not in place.
- This is why we created the PCPCC and want change.

Overview of the PCPCC

- Formed over 18 months ago;
- Over 100 signing members;
- Advancing the Patient Centered Medical Home (PCMH) concept in the public and private sectors;
- Hosting Meetings, Summits, and Congressional Briefings;
- Weekly call Thursdays at 11:00 AM Eastern time. The call-in information is (641) 715-3200, Passcode 421814#. All organizations are welcome; and
- Structured as 501(c)(6) business association with an affiliated 501(c)(3) charitable foundation.

Partial Membership List

Patients:

- AARP
- AFL-CIO
- American Heart Association
- National Consumers League
- National Partnership for Women & Families
- Service Employees International Union (SEIU)

Payers:

- Aetna
- BlueCross BlueShield Association
- CIGNA
- Health Care Service Corporation
- Humana, Inc.
- WellPoint, Inc.

Purchasers:

- The Dow Chemical Company
- General Mills, Inc.
- General Motors
- IBM
- Microsoft
- Wal-Mart

Providers:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American Board of Medical Specialties
- American College of Cardiology
- American College of Physicians
- American Osteopathic Association

Collaborative Principles

The Patient Centered Primary Care Collaborative is a coalition of major employers, consumer groups, organizations representing primary care physicians, and other stakeholders who have joined to advance the patient centered medical home. The Collaborative believes that, if implemented, the patient centered medical home will improve the health of patients and the health care delivery system.

Employers, consumers, physicians and payers have agreed that the patient centered medical home can be an important step toward creating payment systems for physicians that reward value. Compensation under the Patient Centered Medical Home model would incorporate enhanced access and communication, improve coordination of care, rewards for higher value, expand administrative and quality innovations and promote active patient and family involvement.

The Patient Centered Medical Home model will also engage patients and their families in positive ongoing relationships with their physicians. Further, the Patient Centered Medical Home will improve the quality of care delivered and help control the unsustainable rising costs of healthcare for both individuals and plan-sponsors.

Action Items Completed

- Joint Principles of the Patient-Centered Medical Home signed by the AAFP, AAP, ACP, and AOA;
- Assembled the evidence of quality improvement and cost reduction;
- Designed the hybrid blended payment model in conjunction with the AAFP, AAP, ACP, and AOA;
- Educating policy makers and the private sector; and
- Ensuring the implementation of the Patient Centered Medical Home model in most current major health reform proposals.

Collaborative Centers

- Center for Multi-Stakeholder Demonstration: Identify community-based pilot sites in order to test and evaluate the concept; offer hands-on technical assistance, share best practices, and identify funding sources to advance adoption.
- Center to Promote Public Payer Implementation: Assist state Medicaid agencies and other public payers as they implement and refine programs to embed the Patient Centered Medical Home model by offering technical assistance; sharing best practices and giving guidance on the development of successful funding models.
- Center for Health Benefit Redesign and Implementation: Create standards and buying criteria to serve as a guide and tool for large and small employers/purchasers in order to build the market demand for adoption of the Medical Home model.
- Center for eHealth Information Adoption and Exchange: Evaluate use and application of information technology to support and enable the development and broad adoption of information technology in private practice and among community practitioners.

Taskforce for Implementation of the PCMH Model in State Medicaid & SCHIP Programs

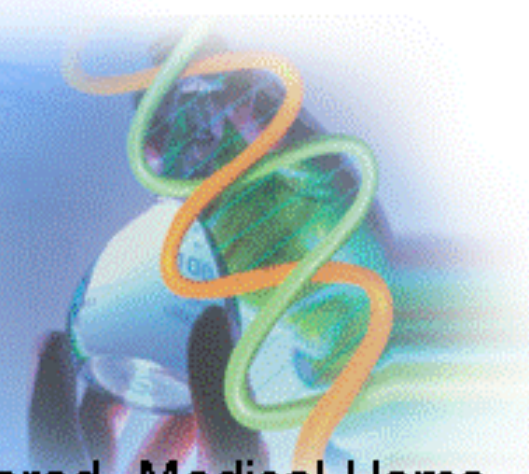
In late 2007 The Commonwealth Fund awarded a grant to the National Academy for State Health Policy and the PCPCC to establish a joint task force to promote the Medical Home in Medicaid and to provide technical assistance to states already seeking to transform their Medicaid programs.

This is a one-year project running through November 2008, and is already well underway.

- The Task Force has already recruited a small number of nationally recognized experts from all sectors of the health industry to advise us on the grant project.
- NASHP has surveyed states and is tracking how Medicaid officials view the Medical Home concept in their states, as well as, attempting to gauge the various underlying difficulties that states will have to overcome during the implementation phase.
- We are scheduled to hold a series of 4 webcasts ranging in topics from general information on the PCMH to structural implementation at the state level, technical reports and papers to assist state Medicaid programs, and a one and a half day Summit here in Washington, DC which will take place on July 29th and 30th.



Global Well-being Services & Health Benefits



NASHP/PCPCC WEBCAST Patient-Centered Medical Home

Paul Grundy, MD, Chair, The Patient Centered Primary Care Collaborative

March 6th 2008

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Doctor-Patient Relationship



A long term relationship with your primary care doctor can result in better overall family health...

Primary care focused on the patients needs is the Foundation on which we need to build Healthcare Transformation

There is no doubt that we face major problems both in health care quality and costs. The crucial question for the Employer (Buyer) is how to respond to these issues.

There is a solution ----- .

Simply stated, the problems of health care quality and cost are, to a very large extent, failures of the way we have organized and designed care in the United States. More specifically, the current failures in healthcare are failures of primary care—the inadequate system design of the primary care practice, the inadequate reimbursement of primary care, and the poor organization of other health care resources, such as hospitals and specialists around primary care. Therefore, any initiative that strives to improve the overall quality and cost of care must focus on the doctor patient relationship in comprehensive primary care.

Since the key is the comprehensive doctor patient relationship this has to be sorted out with the primary care physicians -- this transformation that is required has to be done in collaboration with the primary care physicians. The solution has to benefit the doctor, the patient, the buyer and the payer.

nejm.org august 31, 2006 The impending collapse of primary care medicine and its implications for the state of the nation's health care. Washington, D.C.: --- American College of Physicians, January 30, 2006. (Accessed August 10, 2006, at http://www.acponline.org/hpp/statehc06_1.pdf.) Grumbach K, Selby JV, Damberg C, et al. Resolving the gatekeeper conundrum: what patients value in primary care and referrals to specialists. JAMA 1999;282:261-6



Primary Care: An Impossible Job?

“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still... The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among doctors.”

Morrison and Smith, BMJ 2000;321:1541



Primary Care: An Impossible Job?

- Because of inadequate reimbursement, primary care physicians need excessively large patient panels to keep their practices viable. The average US primary care patient panel is 2300.
- A primary care physician with a panel of 2500 average patients would need to spend 7.4 hours per day performing recommended preventive care [YARNALL ET AL. AM J PUBLIC HEALTH 2003;93:635]
- A primary care physician with a panel of 2500 average patients would need to spend 10.6 hours per day performing recommended chronic care [OSTBYE ET AL. ANNALS OF FAM MED 2005;3:209]



Why Should We Care?

Evidence clearly suggests that sufficient access to high quality Primary Care results in lower overall health care costs and lower use of higher cost services, i.e. specialists, ER, inpatient care

- Adults with a primary care physician rather than a specialist as their personal physician
 - 33% lower annual adjusted cost of care
 - 19% lower adjusted mortality, controlling for age, gender, income, insurance, smoking, perceived health (SF-36) and 11 major health conditions
[FRANKS AND FISCELLA. J FAM PRACT 1998;47:103]
- Increased primary care to population ratios are associated with reduced hospitalization rates for 6 ambulatory sensitive conditions [PARCHMAN AND CULLER. J FAM PRACT 1994;39:123]
- Health care costs are higher in regions with higher ratios of specialists to generalists [WELCH ET AL. NEJM 1993;328:621]



Current Challenge

The Environment: Primary Care currently operates on a transaction-based model and reimbursement does not recognize the value of and specifically reimburse for individualized, comprehensive care management.

The Result:

- Significant reductions in physicians entering into and remaining in Primary Care Specialties
- Poor access to Primary Care
- Escalation of care unnecessarily into higher cost settings (e.g., Emergency Care, frequent Specialist visits, inpatient)
- Suboptimal resource management
- Diminished health outcomes – particularly for those with chronic disease and behavioral health issues



Patient-Centered Medical Home Defined*

Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care of adults, youth and children. **The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.**

Principle Characteristics of PC-MH:

Personal Physician

Physician Directed Practice

Whole Person Care Orientation

Coordinated Care

Quality and Safety

Enhanced Care Access

Full Value Payment

*As originally defined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians, American Osteopathic Association (AOA)



Reimbursement Model

Reimbursement will be a combined Fee for Service (FFS) and PMPM Fee for all attributed practice patients.

- Enhanced payment derived through improved resource utilization (within the care system).
- Physicians remain on current contracted fee schedules and will be reimbursed based on services provided.
- Monthly PMPM supplement based upon quality, efficiency, and satisfaction improvements.
- PC-MH is grounded in providing more comprehensive and coordinated care; it is not about delivering less care to the patient – it is not capitation.
- We project primary care FFS reimbursement may increase by approximately 10 - 15%.
- Potential upside gain sharing will be explored based on pilot practice performance and actual medical cost savings realized.



Pilot Approach

In early 2008, UnitedHealthcare's PC-MH national pilot is proposed to launch in the Denver, Colorado; Providence, Rhode Island; and Tampa, Florida markets

RANDOMIZED DESIGN

In order to validate the success of the PC-MH model, practice groups meeting the PC-MH pilot qualifications in each market will be randomly assigned to participate as a pilot practice site. A subset of those practices meeting the qualifications, but not selected as a pilot practice site, will serve as the comparison ("control") group.

- 24,000-30,000 patients split evenly between intervention and control practices
- Total of 12-15 unique intervention practice sites
- Pilot will focus on adult practices (Internal Medicine and Family Physicians)
- The pilot duration is 24 months

Why Patient-Centered Medical Homes are Important: Impact on Quality and Cost

Melinda Abrams, MS

The Commonwealth Fund

March 6, 2008

www.commonwealthfund.org

**National Academy for State Health Policy and
Patient-Centered Primary Care Collaborative
State Medicaid Webcast**

Why Is Primary Care Important?

Better health outcomes

Lower costs

Greater equity in health

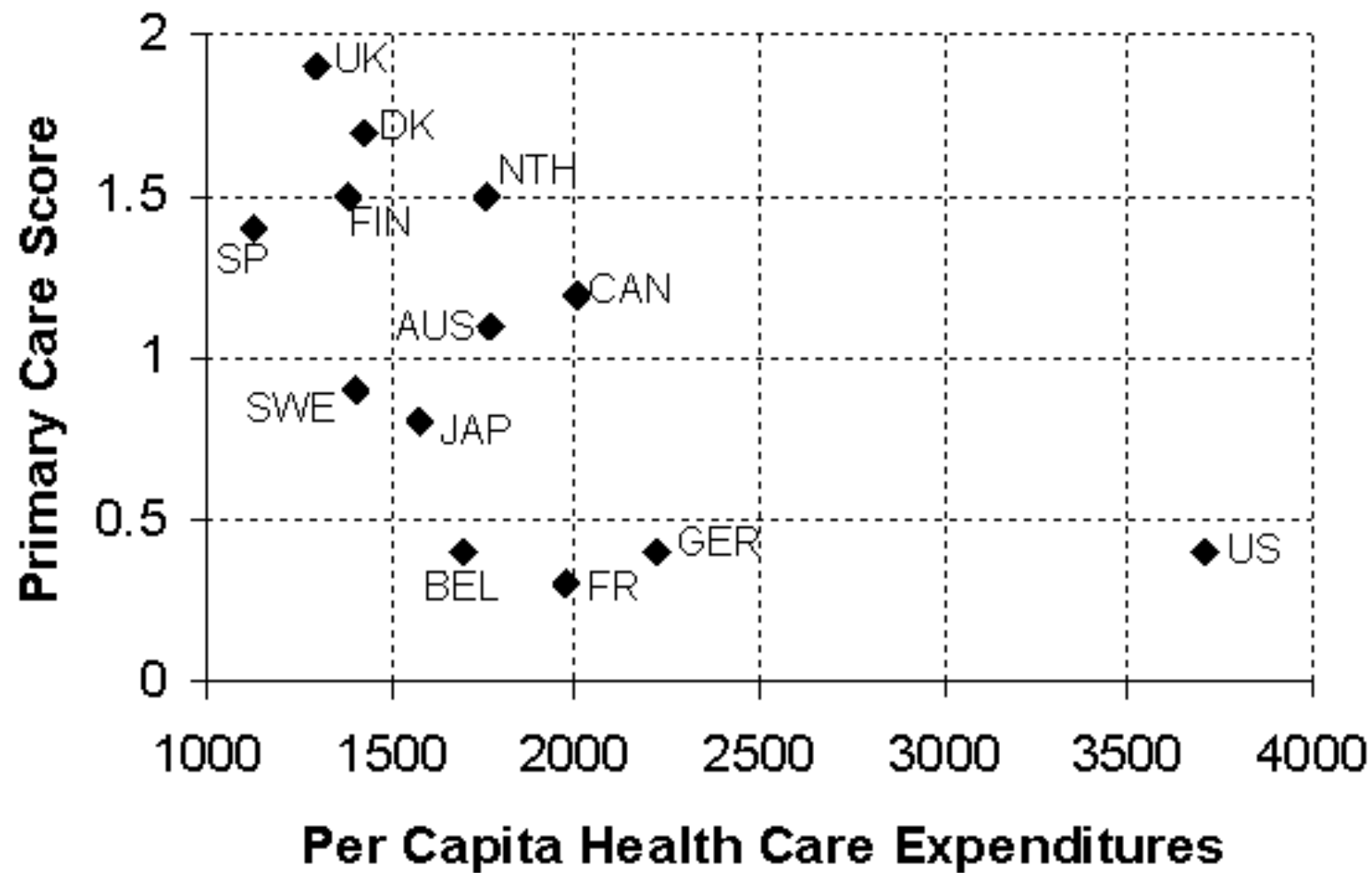
Source: Barbara Starfield, October 2006

Starfield 09/04
04-134

21



Primary Care Score vs. Health Care Expenditures, 1997



Why Are Medical Homes Necessary?

HIGH PERFORMANCE

Toward Higher-Performance Health Systems: Adults' Health Care Experiences In Seven Countries, 2007

Actual experiences with health care systems bring to light, and the systemwide problems in these countries.

by Cathy Schoen, Robin Osborn, Michelle M. Doty, Meghan Bish Jordan Peugh, and Nandita Murukutla

ABSTRACT: This 2007 survey compares adults' health care experiences in Australia, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. In all countries, the study finds that having a "medical home" that is accessible, coordinate care is associated with significantly more positive experiences. There are country differences in access, after-hours care, and coordination but also areas of concern. Patient-reported errors were high for those seeing multiple doctors or with multiple chronic illnesses. The United States stands out for cost-related access to less-efficient care. [Health Affairs 26, no. 6 (2007): w717-w734 (published online October 2007); 10.1377/hlthaff.26.6.w717]

ALL MAJOR INDUSTRIALIZED COUNTRIES are confronting the challenge of providing their populations with accessible, high-quality, safe, and efficient health care. As initiatives seek to improve performance, views and experiences offer insights into a health care system's points of opportunity to improve. Thus, with a focus on access, primary care, coordination, and safety, the 2007 Commonwealth Fund International Health Survey interviewed adults in seven countries: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States.

Cross-national and regional studies within the United States find that accessible, comprehensive, and well-integrated primary care is associated with better outcomes and lower costs.¹ Furthermore, recent U.S.-based studies find



CLOSING THE DIVIDE: HOW MEDICAL HOMES PROMOTE EQUITY IN HEALTH CARE

RESULTS FROM THE COMMONWEALTH FUND
2006 HEALTH CARE QUALITY SURVEY

Anne C. Beal, Michelle M. Doty, Susan E. Hernandez,
Katherine K. Shea, and Karen Davis

June 2007

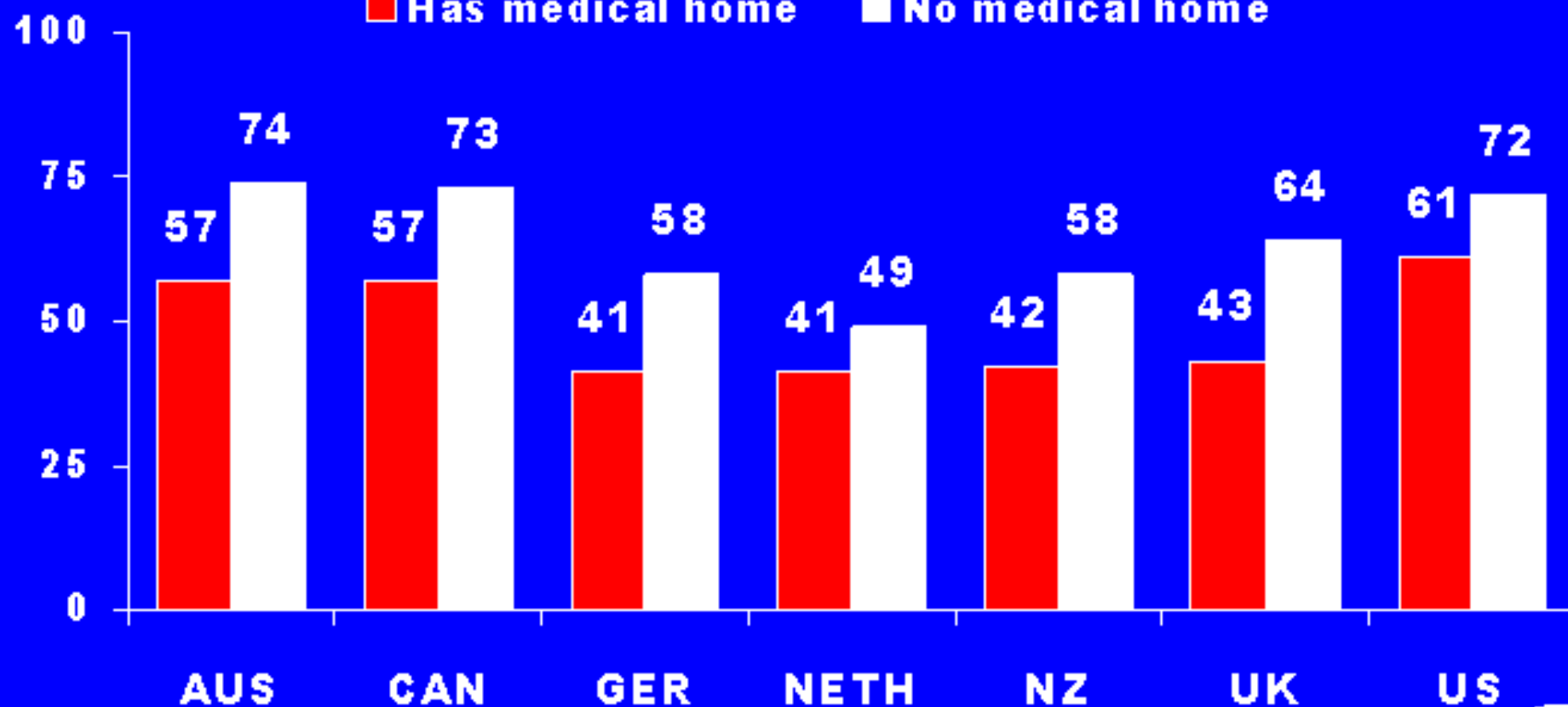
2007 International Survey Indicators of A Medical Home: U.S.

Indicator	Percent
Patient has regular doctor or place of care	90
Doctor/staff know important information about patient's history	74
Place is easy to contact by phone during regular office hours	57
Doctor/staff help coordinate care received from other doctors/sources of care	50
All four indicators of Medical Home	50

Access: Patients with a Medical Home Less Likely to Report Difficulty Getting Care on Nights, Weekends and Holidays (Without Going to the ER)

Percent reporting very/somewhat difficult

■ Has medical home ■ No medical home

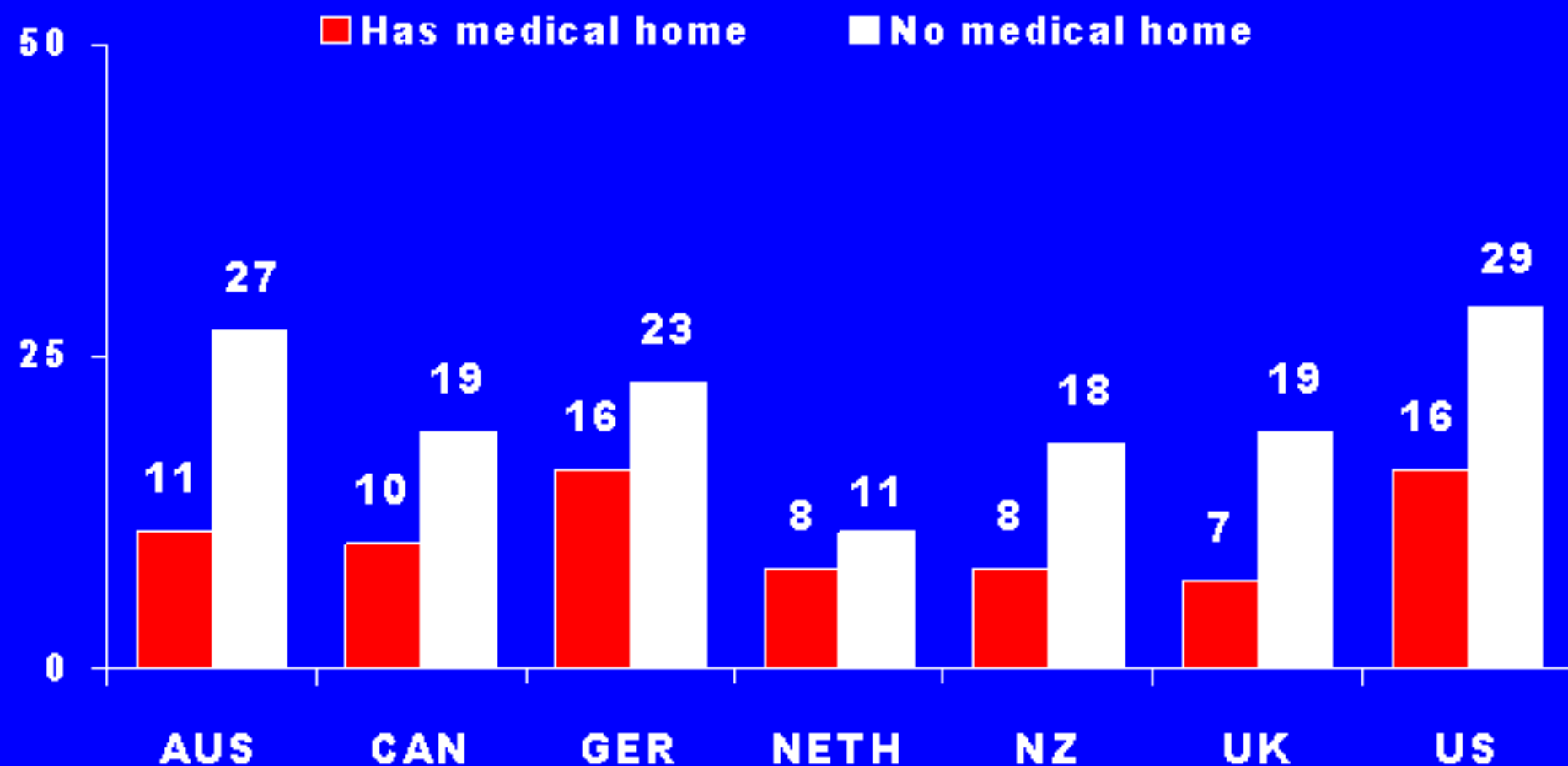


Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.

Source: 2007 Commonwealth Fund International Health Policy Survey

Coordination: Medical Records Not Available During Visit or Duplicative Tests, by Medical Home

Percent adults reporting



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.

Source: 2007 Commonwealth Fund International Health Policy Survey

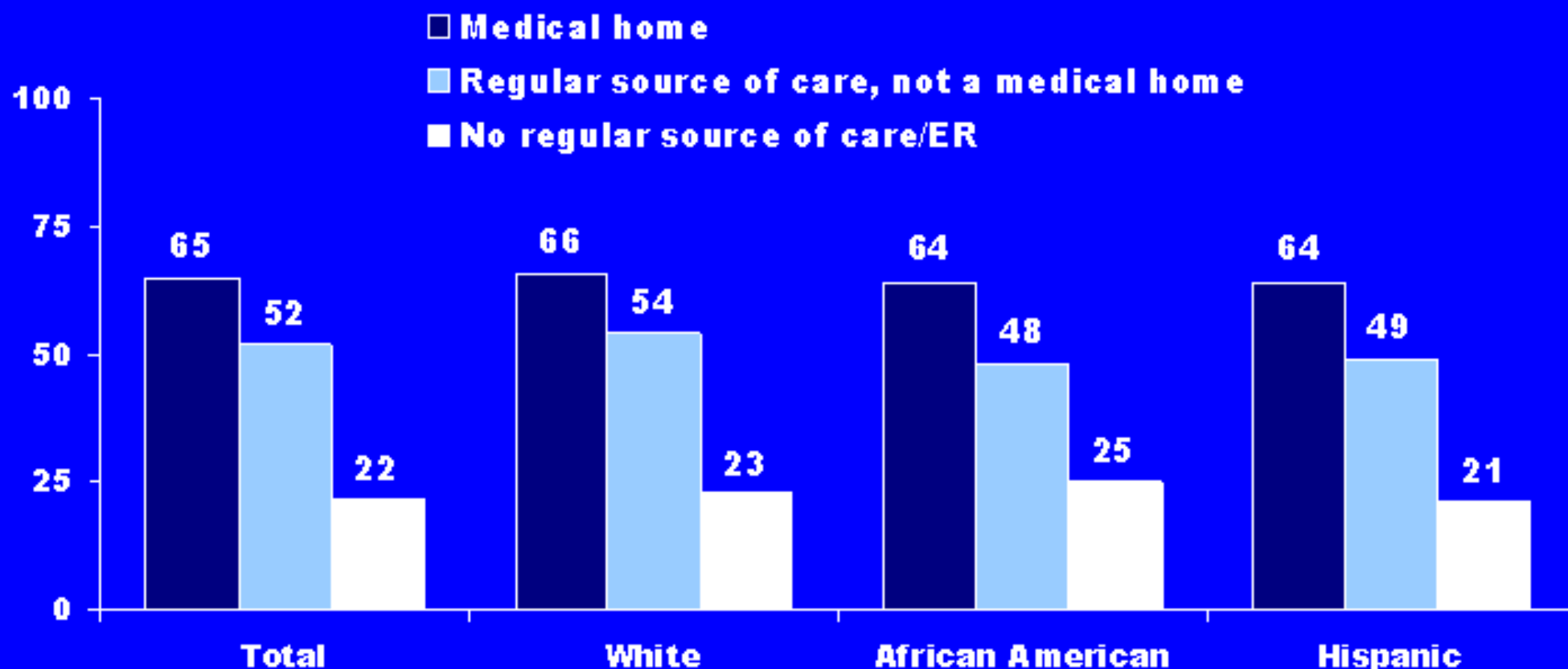
Indicators of A Medical Home

U.S. Adults 18-64

Total		
Indicator	Millions	Percent
Regular doctor or source of care	142.2	80
Not difficult to contact provider over telephone	125.7	85
Not difficult to get care or medical advice after-hours	96.7	65
Doctor's office visits are always or often well organized and running on time	97.1	66
All four indicators of Medical Home	47.2	27

When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office

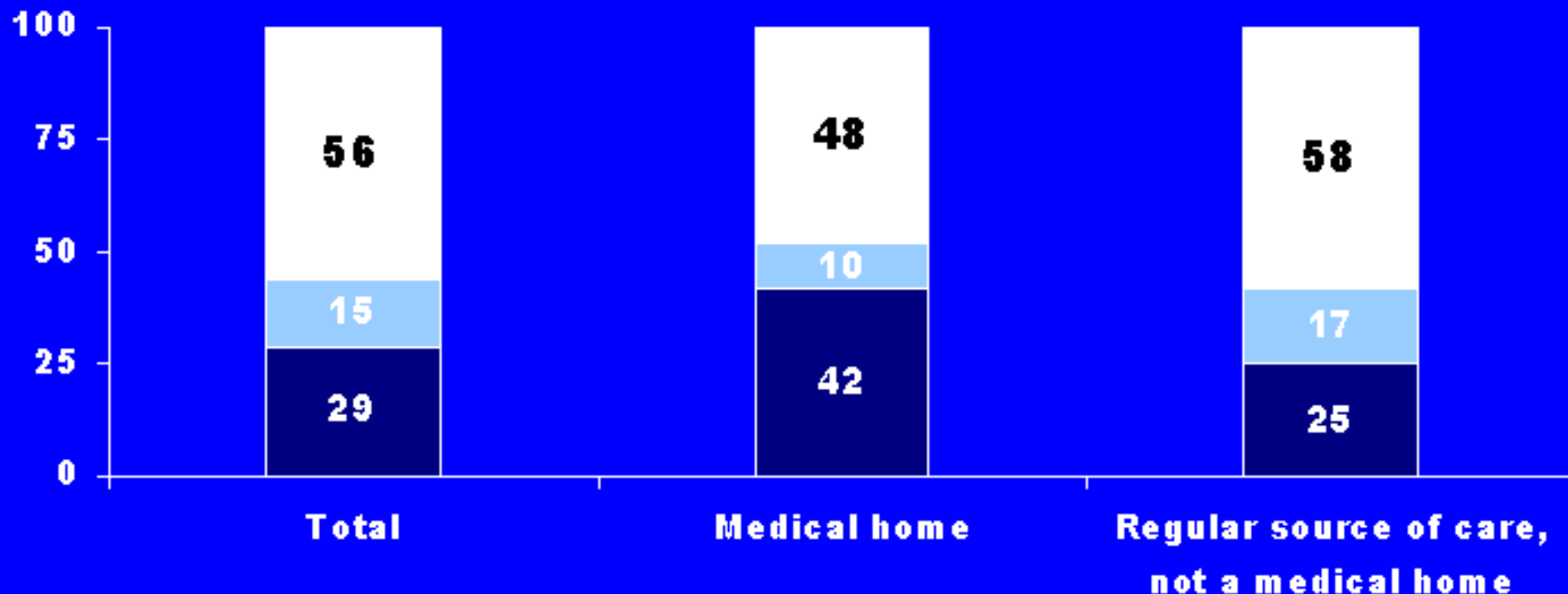


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 10. Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

Percent of adults 18–64 with high blood pressure

- Does not check B P
- Checks B P, not controlled
- Checks B P, controlled



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Medical Home System of Care Offers Opportunity to Save Health Care Costs: Community Care of North Carolina

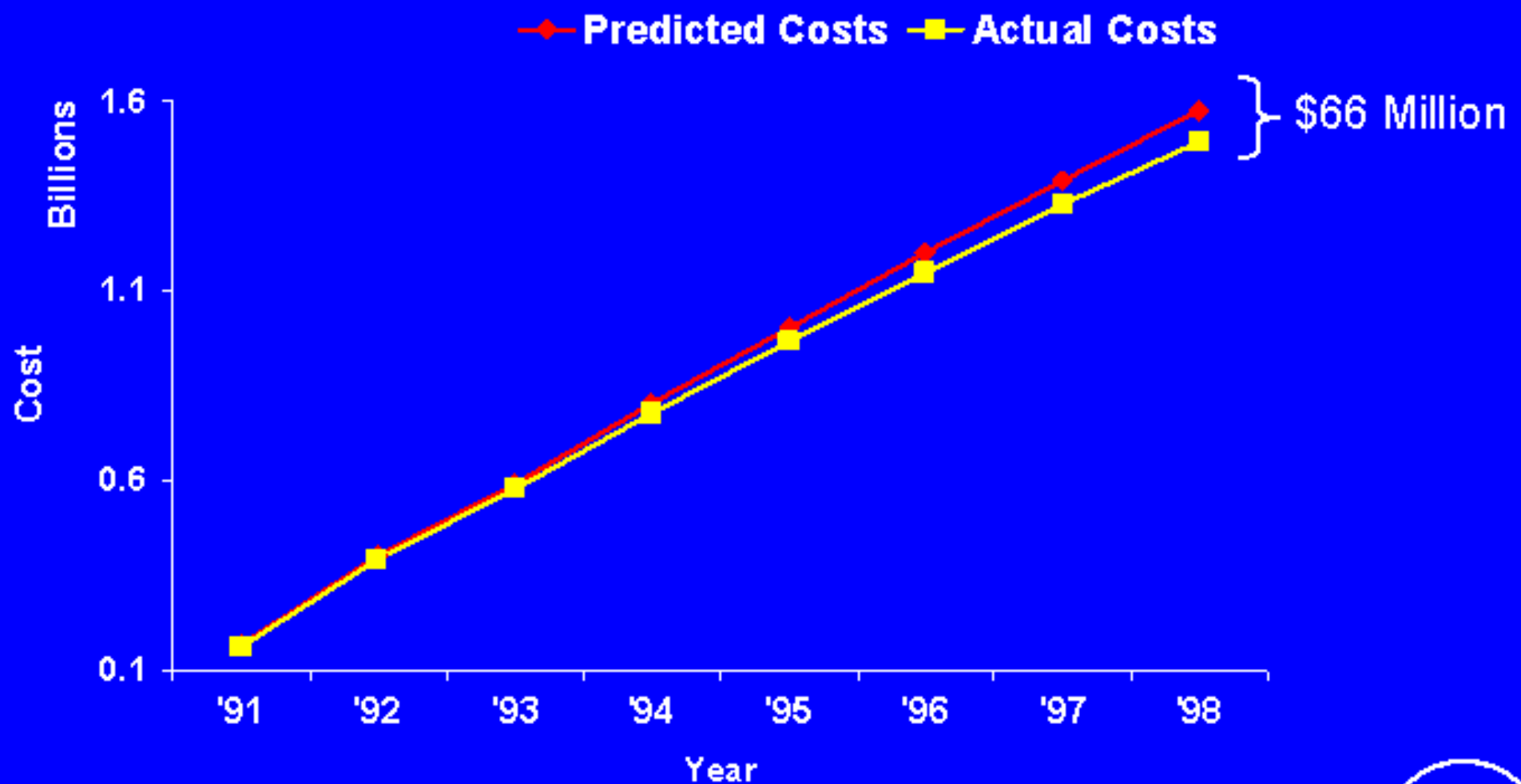
In FY 2003:

- CCNC operating costs totaled \$8.1 million
- CCNC saved \$60 million compared to FY 2002
- CCNC saved \$203 million compared to FFS

In FY 2004:

- CCNC operating costs totaled \$10.2 million
- CCNC saved \$124 million compared to FY 2003
- CCNC saved \$225 compared to FFS

Iowa Medicaid Saved \$66 million 1991-1998



Momany, E.T., et al., A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program, *HRS: Health Services Research* 41:4, Part 1 (August 2006)

Acknowledgements



**Elizabeth Hodgman,
Program Assistant,
Patient-Centered Primary Care
Initiative**



**Katherine Shea,
Research Associate**

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www.commonwealthfund.org**

Questions?

Reimbursement strategies Medicaid and SCHIP programs can use to support and reward medical home performance

Presented by:

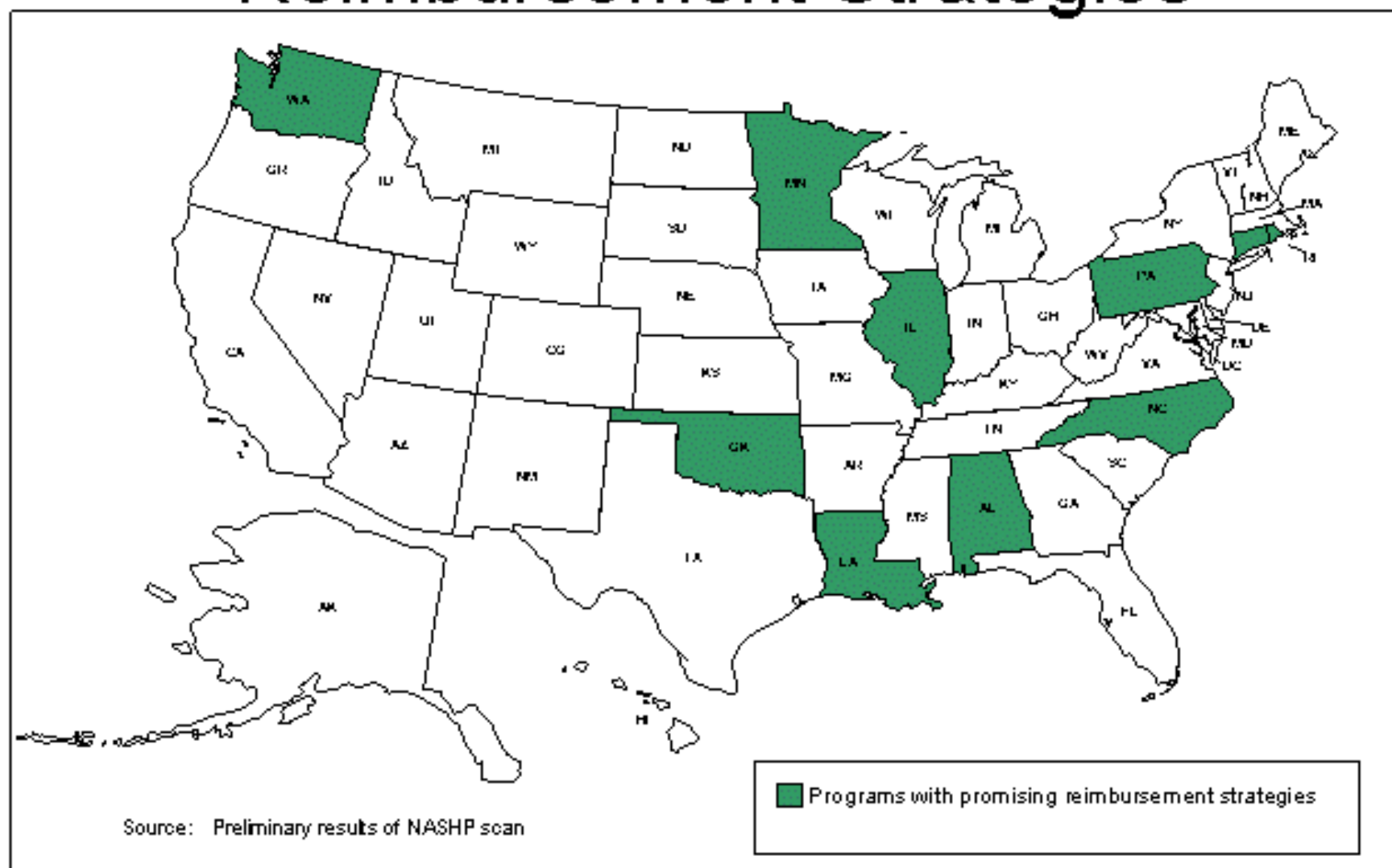
Neva Kaye

Senior Program Director
National Academy for State Health Policy

March 6, 2007

*The Commonwealth Fund is supporting the
Taskforce for Implementation of the Patient-centered Medical Home Model in
State Medicaid And SCHIP Programs*

Medicaid/SCHIP Programs with Promising Reimbursement Strategies



Strategies identified in both major types of delivery systems

- Primary Care Case Management (PCCM)
 - Primary care providers (PCPs) provide primary care and manage other care
 - PCPs paid fee-for-service for services they provide and per member per month PCCM fee to recognize cost of medical home functions
- Capitation
 - Per member per month payment to cover costs of services and management
 - May contract to deliver (1) comprehensive set of benefits including primary care or (2) limited set of benefits, such as primary care-only

PCCM Delivery Systems

- Seven states support and reward practices through PCCM programs
- Five states vary PCCM fee based on characteristics of the practice or member (AL, IL, MN (planned), RI, PA)
- Three states offer reimbursement in addition to PCCM fee (AL, LA, NC)

Capitated Delivery Systems

- Four states support and reward practices in capitated systems
- One state offers performance incentives to HMOs for performance relevant to effective medical home (RI)
- Three others are developing programs for the same purpose (CT, OK, WA)

Putting the Pieces Together: How Rhode Island and Alabama are using reimbursement to support medical homes

Rhode Island

Christopher Koller, Commissioner

Rhode Island Office of the Health Insurance Commissioner

and

Robyn Hoffmann, Consulting Manager for Quality Improvement

ACS, Inc. for the Rhode Island Department of Human Services

Alabama

Carol Steckel, Commissioner

Alabama Medicaid Agency

The Rhode Island Chronic Care Sustainability Initiative:

***Using Medicaid Experience and
Medical Home Principles to Create
a All Payer Pilot***

***Christopher Koller
Health Insurance Commissioner
State of Rhode Island***

What is CSI Rhode Island?

- A statewide, multi-stakeholder collaborative effort designed to:
 1. Collectively **align** quality improvement **goals** and financial **incentives** among Rhode Island's health plans, purchasers and providers, in order to develop and support a **sustainable** model for the delivery of chronic illness care in primary care settings, based on principles of the Patient Centered Medical Home.
 2. **Enhance payment to primary care** providers for the delivery of high quality chronic illness care.
 3. **Build on Experience of Medicaid** in building and promoting Primary Care

Genesis of Program: Local factors

- State interest in primary care sustainability:
 - Governor's initiative in "balanced healthcare"
 - Rlte Care experience with Managed Care and PCP focus.
 - Medicaid interest in developing primary care infrastructure and reducing costs for chronic disease.
 - Regulatory Authority – creation of OHIC
- Provider/consumer dissatisfaction – the FFS treadmill.
- Existing multi-stakeholder collaboration
- Existing practice assistance infrastructure
- Funding Opportunity:
 - Center for Healthcare Strategies' "Regional Quality Initiative"

History - Success of Medicaid Managed Care in RI depends upon role of Primary Care

- RIte Care established in 1994 – three health plans and 125,000 enrollees.
- All enrollees required to select PCPs. Plan payment varies: FFS and capitation.
- Commitment to Evaluation: Documented improvements in prenatal care, preventive health measures.
- Money:
 - State earmarks supplemental money for PCPs through health plans.
 - State has supplemental incentive programs to health plans for improved performance in key conditions and preventive measures.

Rite Care's Performance Goal Program

- Is the second oldest Medicaid pay-for-performance program in the U.S.
- Entered its 10th year in State FY 2008
- Is a key component of the State's value-based purchasing for initiative for Medicaid
- Relies primarily upon a series of HEDIS® and CAHPS® measures

Rite Care's Performance Goal Program

Medical Home/Preventive Care Measures:

- 45% of the overall points available to Health Plans are in this category
- HEDIS® and CAHPS® measures are used
- Performance is evaluated based upon whether the Health Plans met or exceeded the Quality Compass® 90th or 75th percentile for each of these measures

Rite Care's Performance Goal Program

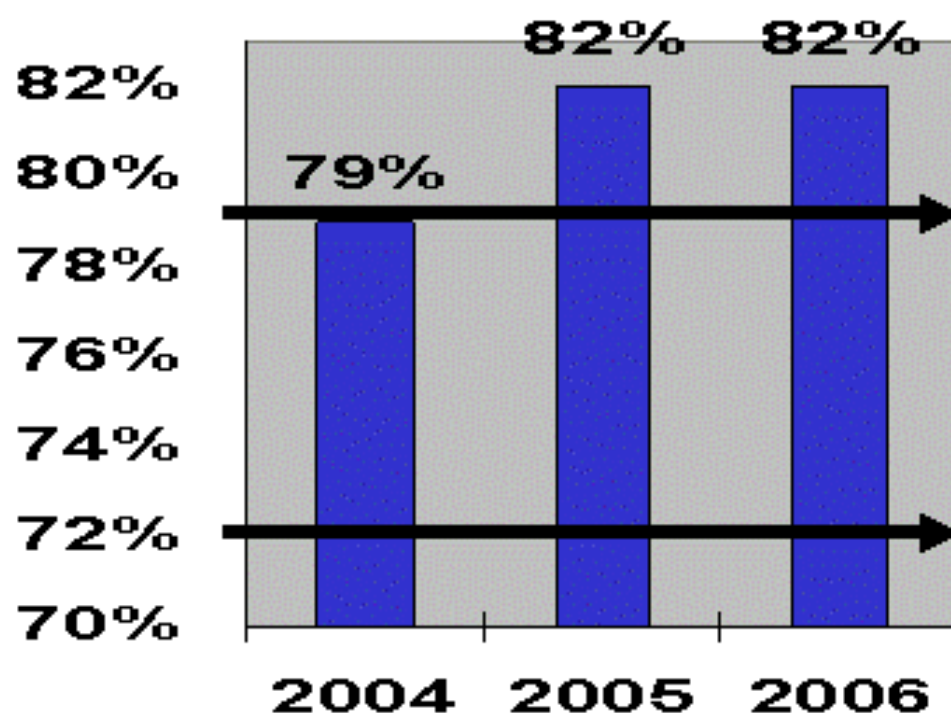
Examples of Medical Home/Preventive Care Measures:

- Adults' Access to Preventive/Ambulatory Health Services (HEDIS®)
- Children & Adolescents' Access to Primary Care Practitioners (HEDIS®)
- Well Child Visits in the First 15 Months of Life (HEDIS®)
- Well Child Visits in the 3rd, 4th, 5th, or 6th Years (HEDIS®)

Rlte Care Performance Trends: 2004 – 2006

CAHPS® Measure:

Rating of Health Plan



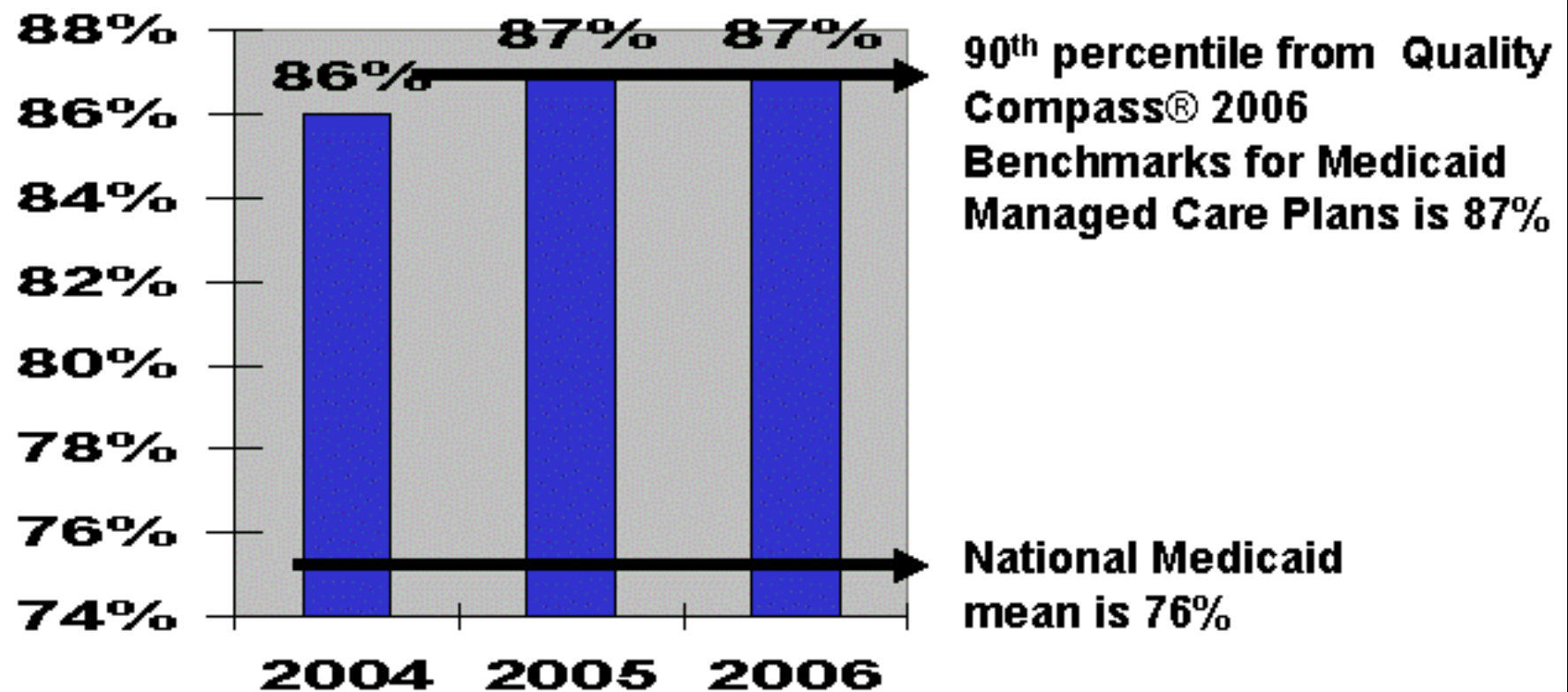
90th percentile from
Quality Compass®
2006 Benchmarks for
Medicaid Managed
Care Plans is 79%

National Medicaid
mean is 72%

Rite Care Performance Trends: 2004 – 2006

HEDIS® Measure:

Adults' Access to Preventive Services Enrollees 20 – 44 Years Old

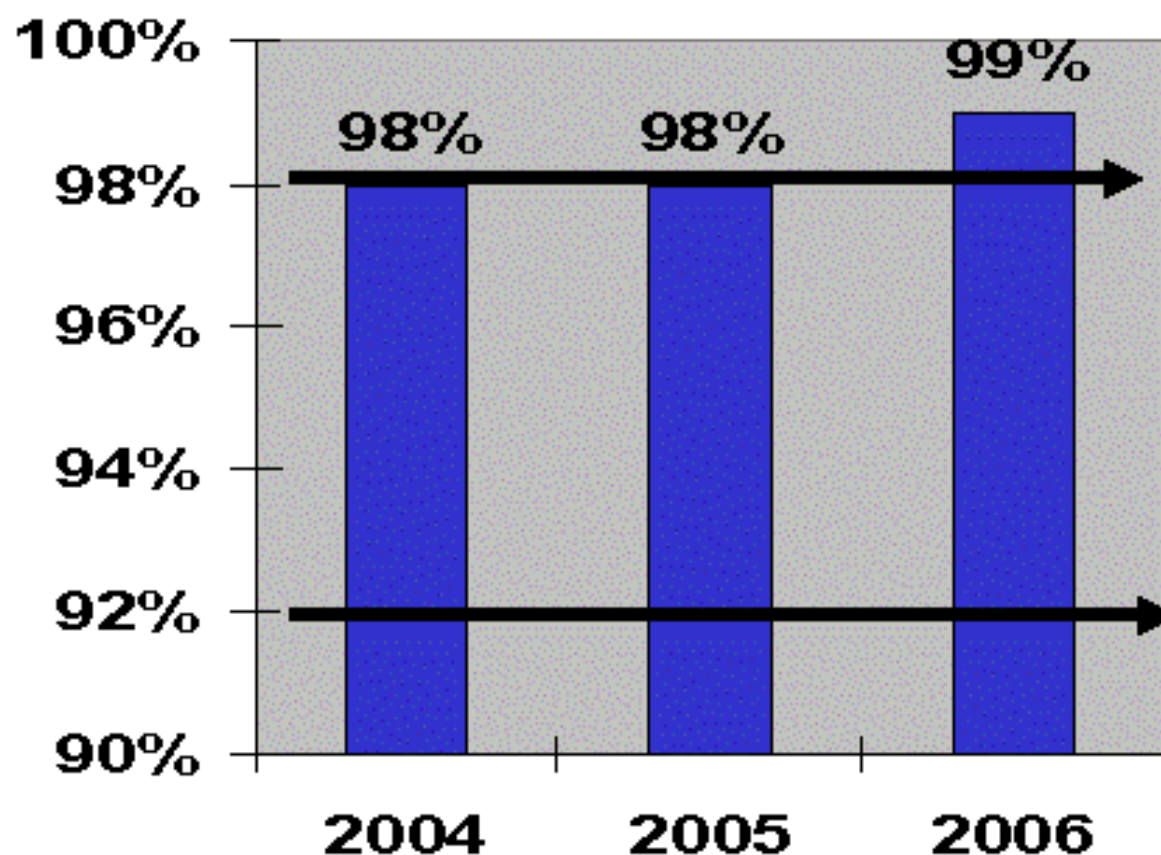


Rite Care Performance Trends: 2004 – 2006

HEDIS® Measure:

Children's Access to PCPs

(Enrollees 12 – 24 Months Old)



**90th percentile from
Quality Compass®
2006 Benchmarks
for Medicaid
Managed Care
Plans is 98%**

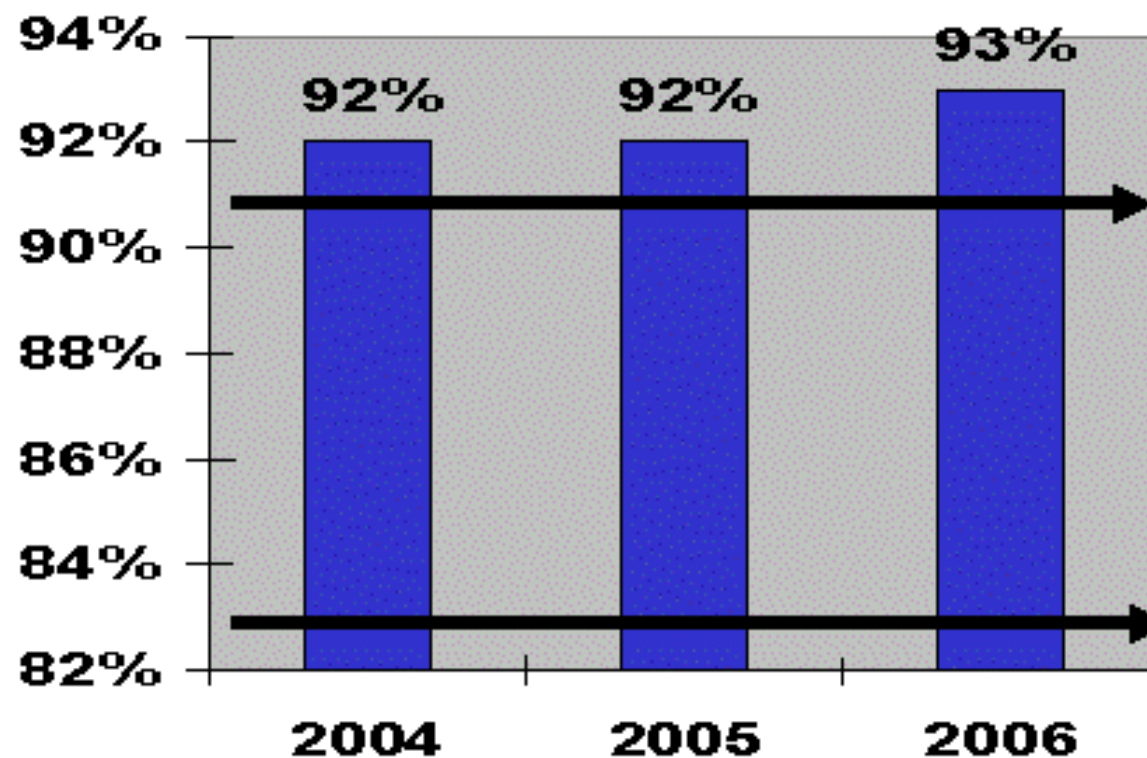
**National
Medicaid mean
is 92%**

Rite Care Performance Trends: 2004 – 2006

HEDIS® Measure:

Children's Access to PCPs

(Enrollees 25 Mos. – 6 Years of Age)



**90th percentile
from Quality
Compass® 2006
Benchmarks for
Medicaid
Managed Care
Plans is 91%**

**National
Medicaid mean
is 83%**

Effect of Rite Care's Performance Goal Program

- Focus Health Plans on Primary Care and Prevention Measures
- Lay a strong programmatic base of measurement and evaluation.
- Build the public case for the value of Primary Care and Medicaid Managed Care
- Draw a Stark Contrast with the poorly coordinated, technically-biased commercial insurance world
(Context for CSI-Rhode Island Project)

Participants in CSI Rhode Island

- **Payers** (representing 67% of insured residents)

Medicaid; all RI-based commercial payers (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, United HealthCare – New England)

- **Purchasers** (including 70,000 self-insured residents)

The two largest private sector employers (Care New England, Lifespan) Rhode Island Medicaid, State Employees - health benefits program, Rhode Island Business Group on Health

- **Providers**

Largest primary care provider organizations (including Community Health Centers and hospital based clinics), Rhode Island Medical Society, RIAAFP, RI ACP

- **State**

Office of the Health Insurance Commissioner, Department of Human Services, Department of Health, Economic Development Corporation

- **Technical Experts**

Department of Health; Quality Improvement Organization

Why An All-Payer Initiative?

Improved Quality, Reduced Costs, Stronger Primary
Care

Fundamental Changes in Care Delivery
(The PCMH)

Investment in New Delivery Systems at the Practice
Level (not at Health plan or Provider level)

CSI RI – Scope of Pilot

Financial Commitment:	Roughly \$1.9 million in practice payments committed by health plans for 2-year pilot
Practice Sites:	5 (3-8 providers per site. One FQHC, one high-volume Medicaid site)
Provider FTEs:	28
Patients:	Roughly 26,000 adults

How do you build an All-Payer Initiative?

Elements of the CSI RI Pilot

- ***Common Practice Sites***

All payers will select the same core group of practice sites in which to administer their pilot

- ***Practice Site Commitments***

Services defining a PCMH - Meet PPC Standards

Participate in local collaboratives - training for chronic care model

Measure improvement for three conditions

Improvement in utilization of ER and inpatient admissions (10% reduction from baseline)

Quarterly collective review meetings

- ***Health Plan Commitments***

Supplemental PMPM for all patients enrolled at site (common attribution methodology)

On site RN Care Management resources

Focused practice-specific reporting.

Quarterly review meetings

Shared ROI analysis

CSI Key Services: How do they compare?

PCMH Principles	PPC “Must Pass” Elements	CSI Key Services
Personal Physician		Identify provider panels; regularly reconcile with plans
Physician-directed care		
Care coordination/integration	Test/referral tracking follow-up	Provide care management services: co-location, planned visits, community resources, group visits
Whole person orientation	Actively support patient self-management	<ul style="list-style-type: none"> •Provide self-management support •Share guidelines with patients

CSI Key Services: How do they compare?

PCMH Principles	PPC “Must Pass” Elements	CSI Key Services
Quality and safety	<ul style="list-style-type: none"> • Adopt and implement guidelines for 3 conditions • Organize clinical data • Use data to identify important conditions • Measure performance and report 	<ul style="list-style-type: none"> • Use EHR/registry to integrate guidelines, identify patients out of compliance, prompt care • Generate reports • eRx • Remote access
Enhanced access	<ul style="list-style-type: none"> • Written standards for access and Communication • Access and Communication results 	Select one of 4 options for enhancing access
Payment		FFS plus PMPM fee

Payment Elements

- *Current FFS model remains in place*
- *Monthly per member per month fee to each practice for all patients for enhanced PCMH services*
 - *Challenge across different products. Severity adjustment would be nice but higher math...*
- *Plans and providers agree to attribution methodology*
- *No performance incentives: Pilot pays for structural changes and practice assistance. Then measure effects collectively. If project not sustainable – plans cease funding in two years.*

CSI RI Approach to Provider Payment

- *Be transparent*
- *Share as much information as possible across stakeholders*
- *Put objective assessment of costs on the table (developed by CSI members based on local market conditions)*
- *Focus on non-monetary benefits to providers (care management, training, enhanced efficiency, etc.)*

Where is the Project Now?

- Finalizing Care Management Resources and what it means to comply with NCQA PPC standards

Docs concerned about loss of productivity (FFS mindset); Plans don't just want to hand over money. (four payers and five provider groups)

- Write up in MOU and then in separate contract addenda between plans and providers.
- Money will flow in q2 (estimated) and then the hard work starts.

What Could be Stronger:

- **Role of Consumer**

How to make this truly patient-centered - in third party payment system?

- Thinking a little about benefit design
- Hard to do with Medicaid

- **Data analysis**

Once this is up and running, need the measurement to give feedback and improve performance.

- **Role of Business**

Self Insured are at table but business leadership could be stronger.

What's the Return for the Project?

- The Right Thing to do – “Stop the Madness”
- Collective measurement of effects
 - All payer and collaboration is key: You show me yours and I'll show you mine.
 - Build some trust
 - Move beyond the “early adopters” of PCMH
- Return on Investment Analysis
 - Health Plans have calculated the reduction in ER and Inpatient Admissions needed to fund this (source of 10% goal)
 - MDs- greatly concerned about loss revenue associated with loss of productivity. Combating incentives of FFS system

Patient 1st
Alabama's PCCM Program

Carol H. Steckel, MPH
Commissioner

What is Patient 1st?

- Traditional PCCM Program (1915b Waiver)
- Creates a Medical Home
- Links Medicaid Patients With A Primary Medical Provider
- Reinstated December 2004
- Previously Operated 1997–February 2004

Program Highlights

- **Staggered Case Management Fee: Dependent on Contractual Obligations and supports Medical Home Concept**
 - EPSDT Provider: \$0.45
 - VFC Participant: \$0.10
 - Medical Home CME: \$0.10
 - 24/7 Coverage: \$0.85
 - Hospital Admitting Privileges: \$0.30
 - In-Home Monitoring (Disease Management): \$0.10
 - InfoSolutions Participant: \$0.50
 - Electronic Notices: \$0.05
 - Electronic Educational Materials: \$0.15
- **Enhancements**
 - In-Home Monitoring Program
 - InfoSolutions/e-Prescribing
 - Case Management

Shared Savings Program

- Measures Selected Based on Program Impact and Support of Medical Home Concept
- Reported through the Profiler
 - Physician Report Card
- Based on Total \$11.7 million Savings
 - \$5.76 million Shared
 - PMPM calculation in absence of the program
- Distributed through Direct Payment

The Measures

- **Performance**
 - Generic Dispensing Rate
 - Non-Certified Emergency Room Visits
 - Office Visits Per Unique Enrollee
- **Efficiency**
 - Total Patient Cost

The Application

- PMPs compared within their peer group
- All measures and costs adjusted for morbidity
- The \$5.76 million equally divided between performance and efficiency
- Cost based providers did not share in the efficiency pool
- For each measure
 - Actual compared to expected
 - Percent variance determined and ranked
 - Based on ranking, a score is applied
 - Score multiplied against member months to derive share points
 - Share points are then multiplied by their value

Say That Again . . . (an example)

Measure: Generic Dispensing Rate

PMP: 63.7% Expected: 62.1%

Variance: 2.6% Score: 8

Member Months: $1224 * 8 = 9792$

Share Points: $9792 * .0444 = \$434.76$

NOTE: Score applied to variance was determined by ranking all variances and dividing equally. Value of share points was determined by taking total possible points divided into the performance pool.

What Made it Work

- Simple Methodology
- Clear, Defensible Measures
- Involved PMPs in the Decision Making
- “Check Stub” explaining each measure and how the PMP ranked
- A PMP Could Share in Performance and Not Efficiency
- Continual Reporting of the Measures

Next Time

- Ranking and Variance Will Reflect Better Performance vs Just Performance
- Working with Cost Based Providers to Share in Efficiency Pool

Tidbits of the Sharing

- 6.2% of PMPs Did Not Receive Any Amount
- Highest Payment was \$133,661
- Lowest Payment was \$1.69
- Average Payment was XXXXX
- Bottom Quartile of Each Peer Group Excluded
- Performance Value: \$.0444
- Efficiency Value: \$.2105
- http://www.medicaid.alabama.gov/programs/patient1st/patient_1st_shared_savings.aspx?tab=4

The Future

- Together for Quality transformation grant (Electronic Health Record, Electronic Clinical Support Tool, case management, interoperability)
- Creating additional tools for our Primary Care Providers
- Adding other providers such as pharmacists to the system

Ultimate Dream

Pay for Comprehensive Care
NOT
Episodic/Fragmented Care

Questions?

For more information

- The Patient Centered Primary Care Collaborative
 - www.pcpcc.net
 - Edwina Rogers at erogers@eric.org, (202)789-1400
- The Commonwealth Fund
 - www.commonwealthfund.org
- The National Academy for State Health Policy
 - www.nashp.org or
 - Neva Kaye at nkaye@nashp.org; 207-874-6524
- Rhode Island Office of the Health Insurance Commissioner
 - www.ohic.ri.gov or
 - Christopher Koller at ckoller@ohic.ri.gov
- Alabama Medicaid Agency
 - www.medicaid.alabama.gov

Upcoming Events

- Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Infrastructure
 - Recognizing a medical home
 - Strategies to help practices fulfill medical home functions
 - Webcast, April 2, 2008 (tentative)
- State Medical Home Summit
 - Bringing together state officials and national experts
 - July 29-30, 2008 in Washington DC
 - Limited scholarships will be available for state officials
- More details to come from NASHP!

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